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# RECENT TRENDS IN SURGERY OF THE THORAX*

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SURGERY within the thorax has been changing so rapidly during the past few years that it has been difficult to keep pace with its progress.

Within a relatively short time, in addition to improved methods in surgery of the lungs and pleura, complete excision of the thoracic esophagus has been accomplished with reestablishment of direct continuity of the gastro-intestinal tract, while resection of the lower third, the least difficult segment to deal with, has become commonplace. The same may be said of diaphragmatic hernia in its various forms affecting both adults and children, whose hospital stay is now barely longer than that of an uncomplicated inguinal hernia. The transthoracic or the thoraco-abdominal approach to gastric lesions is now employed by every qualified general surgeon, for it is difficult to carry out a satisfactory excision of the upper stomach, especially when dealing with malignancy, by the abdominal route. The same approach is also used for spleno-renal and portalcaval anastomosis in the treatment of portal hypertension.

I am sure that everyone has followed with intense interest the remarkable achievements of those surgeons who have had the courage to lead the attack against congenital vascular deformities by division and anastomosis of the great vessels within the thorax. Following closely upon this is the revival of interest in the surgical treatment of mitral stenosis which up until the present time, though still in the stage of experiment, at least offers hope to the great numbers who suffer from this disabling disease.

There have been so many contradictory reports in the literature, especially those referring to the treatment of the suppurative diseases, that a certain amount of confusion has been created. It is with this in mind that we hope to present very briefly a few illustrative cases[1] in an attempt to at least clarify our own position in this field of surgery.

It has been our good fortune to have had a very active Thoracic Clinic at the Rhode Island Hospital which has enabled us to form some opinions from personal experience. Every week we have the privilege of sitting down with the internist, roentgenologist, bronchoscopist, surgeon, and members of other departments in order to exchange opinions and arrive at some decision about the many cases that come for diagnosis and treatment. This clinic was founded in the year 1937 by Dr. Halsey DeWolf and has continued an uninterrupted service of bi-weekly clinics up until the present time.

During the year just past, 127 new patients have been thoroughly studied, 292 old cases have had follow-up observation and there have been a total of between six and seven hundred clinic visits. A few of these will be presented to you tonight to illustrate our present thoughts in the diseases most commonly encountered.

You are all aware that since the introduction of the antibiotics, acute *empyema* has become a relatively rare disease. But, in spite of the use of penicillin and streptomycin as a therapeutic measure, the fundamental principles which have been emphasized through the years have not changed. The aim of treatment may be simply expressed as disinfection of the pleural cavity and re-expansion of the lung. The open and closed methods still occupy a prominent place in treatment and the indications which govern the use of each and which have found clarification only after years of study should not be forgotten or discarded in a misguided enthusiasm for the so-called conservative methods.

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[1] Several cases were demonstrated with lantern slides.

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The treatment of empyema by aspiration and replacement with penicillin or streptomycin does have a definite place in the scheme of treatment. This, however, should not be undertaken without complete knowledge of its dangers and without a clear understanding of the seriousness of failure.

Certain definite contra-indications to this method do exist, such as very thick pus which does not allow satisfactory aspiration, multiple loculations of fluid, the presence of a bronchopleural fistula or when nonsusceptible organisms are demonstrated.

Chronic empyema which had practically become a thing of the past, is again beginning to show itself as a sequela to failure by non-surgical methods, and requiring major operations for its correction.

When aspiration methods are employed they must be carried out religiously every one or two days with as complete removal of pus as is possible and introduction of varying amounts of penicillin or streptomycin, or both. One should not be satisfied with a clinical response in which the temperature returns to normal and the patient becomes symptom-free. I believe that this has been one of the major pitfalls. In addition the empyema cavity must be completely obliterated before discontinuing treatment, for if such is not the case, a cure has not been achieved and recurrence of symptoms will undoubtedly occur. At this stage simple drainage will probably not suffice and resort to either decortication or thoracoplasty will become necessary.

During the early phase when the fluid is thin and when pneumonitis is a prominent feature of the disease, the antibiotics, both locally and parenterally are valuable adjuncts to treatment. After this point, if they are to be used as a substitute for surgical drainage, great care must be taken to avoid the errors which have been mentioned. For my own part, I much prefer having a catheter in the chest, a procedure which may be accomplished under local anesthesia in about 15 minutes, after which suction may be employed, irrigation carried out, and the antibiotics introduced. I believe that this method is less distressing to the patient than the daily aspirations with a needle, and that it is associated with fewer dangers of late complications.

The open method usually reserved for encapsulated empyema, has the advantage of providing the most satisfactory drainage, and of pursuing a more uncomplicated course, but complete healing occurs more slowly than when a negative pressure is established within the cavity.

Testing the organisms against the antibiotics to determine their susceptibility is an important contribution and is used routinely in all cases.

During the war we learned the value of decortication of the lung in the treatment of organized hemothorax, and this has become our foremost weapon when confronted with a chronic pleuritis. The Schede type of thoracoplasty with its multilating deformities is happily receding to a less prominent place in the empyema picture.

Early drainage of putrid *lung abscess* by a single stage operation has been the accepted treatment of choice during the past few years, and has been rewarded by a marked lowering of mortality. Introduction of the antibiotics has not brought about any appreciable change in this attitude, although as adjuncts to surgical therapy, they occupy a prominent place, especially during the early phase of the disease, both by the parenteral route and as a vapourized inhalant.

As is true of empyema, nonoperative methods must be viewed with caution. That spontaneous recovery may occur in roughly 25% of cases has been appreciated over a long period of time and this figure has been improved with the use of antibiotics. However, the results of early drainage have been so superior to all other methods that it has been accepted without disagreement by internists and surgeons alike.

Surgery may be delayed in those cases which during the early phase show a tendency to rapid resolution, especially if the cavity is small. This is also true where evidence of multiple loculations exist and the chance for satisfactory drainage is uncertain because of the nature or the location of the abscess.

As a general rule a well defined putrid abscess of the lung demands early drainage. This simple operation is performed under local anesthesia in a single stage. To avoid doing so invites either spread of disease or a chronic state which hardly compensates for the smaller percentage of cures which may be obtained.

It has been our experience that a chronic abscess which has been drained even for a long period and with an apparent cure, has a definite tendency to later symptoms, indicative of pulmonary fibrosis and bronchiectasis. Because of this and of the improved results in pulmonary resection, lobectomy should be recommended in the chronic case. The fact that recent series record a surgical mortality of under 5%, should not prompt us to delay early drainage—the latter is a minor procedure while lobectomy under these circumstances must still be considered a formidable undertaking. In addition it should be remembered that many may be lost because of spread of disease, or other complications, making any surgical intervention impossible.

It is hardly necessary to mention the important role that bronchoscopy plays in the indentification and removal of foreign bodies, the promotion of

drainage from an obstructed bronchus and assistance in localization. Suffice it to say it is used routinely in all cases.

The surgical treatment of *bronchiectasis* has been marked by two important contributions which has had the effect of reducing mortality and eliminating most of the complications of earlier days. These are, first, individual dissection and ligation of the structures at the lung root and second, the recognition of the various pulmonary segments.

The former, together with the use of the antibiotics, improvement in anesthesia, and other minor modifications of technique have cut down hospitalization to an average of between one and two weeks. Empyema and bronchial fistula which with mass ligation was almost routine, have become relatively rare.

Segmental resection of lobes has its chief value in those patients with disseminated disease where multiple operations are necessary. It allows us to retain the maximum amount of normal lung tissue and to eradicate those portions of the lungs in which bronchiectasis is demonstrated by lipiodol study.

Although it is obviously impossible to attempt to cover the subject in full, there are a few points about *carcinoma of the lung* that have been of interest to us. The progress with this disease has been an uphill fight, as is true of malignancies in so many other regions, but it has been rewarded by gradual progress which has been reflected in improvement of operative motility, and a lengthening of the period of survival. This has become possible through improving methods in diagnosis and operative technique.

Unfortunately, in the average case this disease is ushered in by no dramatic train of symptoms. Cough, although usually present, may not be severe; and pain and hemoptosis, the two symptoms which most frequently bring patients to the doctor's office, are only present in a little over half of the cases, and more often than not indicate advanced disease.

The number of cases that are resectable has now reached about 35% as compared with 15% five years ago in most series, and of these, the five-year survivals average about 5 to 8%. However, the number of cures is not the only measure of success when we consider that there are many more who are able to return to work and are relieved of their symptoms for a variable period of time.

The campaign to carry out routine chest x-rays in the fight against tuberculosis, if continued to include a large percentage of the population, would be of tremendous help in detecting carcinoma of the lung. Many more earlier cases would be discovered which would be followed by an increase in the number of cures.

Diagnosis, in spite of careful and repeated x-ray and bronchoscopic examinations, is not always easy, and it is most important that the patient not be dismissed until the symptoms and signs are unequivocally explained. If a doubt still exists, exploratory thoractomy should be performed.

We have been impressed by the relatively large number of cases in which the presenting feature is a lung abscess, and which because of their peripheral location may lie beyond reach of the bronchoscope. We have learned to suspect carcinoma in every case of lung abscess in the older age group when the etiology seems obscure. If any doubt exists, resection, rather than drainage, should be carried out, and if drainage is decided upon, careful sections of the abscess wall should be taken for microscopic examination.

Cytologic examinations of sputum preferably from bronchoscopic aspirations has now been added as an aid in diagnosis and has been done routinely in all cases at the Rhode Island Hospital since July 1, 1948. Fifty-four cases have been examined by this method, seven of which have been positive for carcinoma cells. Considerable experience is necessary with this method and it is believed that as time goes on it will become of more value to us as a diagnostic aid. It is especially useful in those cases in which, for any reason, biopsies cannot be obtained.

Surgical excision is the only method by which a cure can be hoped for, although x-ray therapy is of benefit in selected cases. Pneumonectomy is the operation of choice, although occasionally lobectomy is a justifiable procedure.

There has been a certain change in our attitude towards that type of malignancy which invades the chest wall and ribs, and which too often in the past has been looked upon as inoperable. We have found from experience that some of these lesions are more favorable than those more centrally located. There have been several cases in which resection has been carried out along with block removal of the chest wall. Furthermore peripheral lesions may be brought to the attention of the patient at an earlier date because of pain, and may be found to be only locally invasive, without early mediastinal invasion.

The resection of a large segment of the chest wall has a tendency to be followed by complications due to the lack of bony support which in turn may result in mediastinal motion and an unfavorable postoperative convalescence. To overcome this, we have in three cases employed tantalum plate in the area of the defect. This has obviated the dangers of the immediate post-operative period, and when left in place for a few weeks, creates a firm, inflammatory membrane which gives permanent stability to the chest wall.

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# RUPTURED INTERVERTEBRAL DISCS— DIAGNOSIS AND TREATMENT*

LAURENCE A. SENSEMAN, M.D., HANNIBAL HAMLIN, M.D., AND HOWARD UMSTEAD, M.D.

## CLINICAL ASPECTS

The Author. *Laurence A. Senseman, M.D., of Lincoln, R. I., Chief, Neuropsychiatric Service, The Memorial Hospital, Pawtucket, R. I.*

INTERVERTEBRAL DISC, nucleous pulposus rupture, herniation or prolapse of an intervertebral disc all mean the same thing. This subject has only been recognized in the past ten to twelve years and at present has assumed a rather prominent position in the differential diagnosis of low back pain. However, observation with regards to the occurrence of this clinical disorder has been recognized for many years.

The clinical signs and symptoms which are present as a result of an extrusion of a ruptured intervertebral disc are the result of pressure on the contents of the spinal canal; especially the spinal nerve roots. This is especially common between the 4th and 5th lumbar vertebrae giving rise to symptoms which are prone to effect the sciatic nerve. Usually these individuals will give a history of some form of trauma to the back usually of long duration with recurrent attacks of low back pain which may incapacitate them for an indefinite period of time. However, all patients give some history of a traumatic etiology either due to torsion, lifting or pushing some heavy article. Therefore, this occurs most frequently in male individuals in the prime of life but since the history usually goes back many years it may occur in their younger days.

As you know, the intervertebral disc lies between the opposing surfaces of the moveable vertebrae. They are largest in the lumbar region and are perhaps the most inadequately supported at this area, the bottom of the spinal column, and thus in a position to bear the most weight of the vertebral column. This may account for the frequency of herniation here. It has been proven without doubt that repeated sub-minimal trauma as well as some immediate and severe pressure may result in a displaced disc and may cause herniation. It is also interesting to notice that most of these patients present a strikingly similar history and symptomology. From their history and symptoms present one can make a diagnosis very readily and a surgeon recently stated that in 26 consecutive cases without the use of radiopaque solution he was able to make a positive diagnosis in all 26 cases.

The most presistent symptom as presented is low back pain. This is usually acute, is relieved by rest but aggravated by changing positions, coughing, sneezing or straining at stool. The pain may radiate from the back down the sciatic distribution of the nerve; that is, the lateral aspect of the leg, and into the knee, calf and foot. Also associated with the pain the patient complains of numbness or coldness in the leg involved and this is usually in the lateral aspect of the leg or foot or if the disc is in the lumbar sacral area it may produce a saddle like type of anesthesia which is diagnostic of sacral root or cauda equina pathology.

There are other signs associated with this illness which are easily recognized. One is stiffness of the lumbar spine with a loss of the normal curve and associated with some scoliosis, usually to the side opposite the lesion. Also limitation of motion of the legs and special aggravation of pain with Lasegues sign and Kernig sign.

On examination the patient usually presents evidence of neurological disturbance of the nerve roots involved. Thus, one will get a diminished ankle jerk most frequently when the sciatic nerve is involved; also the knee jerk may be diminished as compared with the opposite one. Corresponding disturbances in the upper extremities may be found when dealing with a cervical herniation. There is sensory disturbance, as you may expect, in the distribution of the nerve involved. It is easily found by testing with a pin or cotton. Rarely the vibratory and position sense are disturbed. The anesthesia usually bears some anatomical distribution which is highly suggestive and localizing.

A lumbar puncture is also helpful in that the spinal fluid protein is usually increased, but a normal spinal fluid does not rule out a ruptured

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disc, our experience bears this out. The most significant finding, when present, is the evidence of a block with the Quakenstat test which is highly suggestive of some intraspinal space occupying lesion. This, however, did not occur very frequently in our series of cases. The cell count was not very helpful but usually was slightly elevated.

However, to secure conclusive evidence of the presence of a herniated intervertebral disc a myelogram can be accomplished by putting 3 c. c. to 9 c. c. of Panopaque solution into the spinal canal and under fluoroscopy tilting the patient so that the fluid will run upward or downward in the spinal canal; the presence of a disc is thus outlined by a defect in the column as it passes over the ruptured disc involved between the bodies of the vertebrae.

The following is a summary of the 20 cases which we have recognized here at the Memorial Hospital. All have been proven by operation, 18 of which have been operated on by Dr. Hannibal Hamlin who will discuss the surgical aspect of this condition.

## NEUROSURGICAL ASPECTS

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THE SURGICAL INDICATIONS for intervertebral disc pathology are pain and disability that do not respond to conservative measures. The operation aims to eliminate nerve root pressure which may not be accomplished in some instances after the offending disc is removed unless the low back is stabilized by orthopedic bony fusion. Many degenerated lumbar discs cause low back pain but not nerve root pain because there is no encroachment on the latter structure. The cushion spaces around the foramina in the lumbar segments of the spinal canal exhibit considerable variation in juxtaposition to the adjacent discs. This anatomical relationship and the relative size of spinal canal and dural sac are largely responsible for the 18% inaccuracy of myelography, (224 cases). However, the history and clinical signs are more important than the x-ray findings; and many patients undergo successful surgery in the face of negative spinograms or without benefit of same.

The operation depends on good exposure and demonstration of the compressed structures and complete removal of all degenerated disc substance. Minimal incision and efforts to get at the lesion through a keyhole opening often lead to an inadequate operation and recurrence of symptoms.

The outcome in the cases presented by Dr. Senseman cannot be fully appraised because of insufficent lapse of postoperative time, except to state that the outlook is at least as good as that shown by statistical reports elsewhere. 17 of these cases can be considered improved and over half have resumed working activity. There was one postoperative death from delayed surgical shock in a poor risk woman of 53 with two protruded discs which involved a long and difficult procedure. In this connection we think we have recently improved the anesthetic hazard in this operation by the use of peridural block. Dr. Umstead will comment on this important development which derives from his idea and practice.

We are more interested in the results of this type of surgery than anything else. The fact that half our cases can be considered well and working from 3 to 12 months after operation compares favorably with figures from recent surveys analysing mostly insurance case material where optimism about the end results of intervertebral disc treatment is not stressed.

Several clinics — numerous surgeons — neurosurgery, orthopedic and variable type of therapy.

360 cases with surgery—48% well and working

200 cases without surgery—29.5% well and working—63 still under nonsurgical treatment—20% obtained relief by changing job.

289 cases without spinal fusion— 52% well and of these 93.8% working.

66 cases with spinal fusion—33% well.

Cases without fusion—36.4% still had back pain —8% had back and leg pain.

Cases with fusion—41.5% still have back pain—10% have back and leg pain.

Cases without compensation—60.4% well and 32.5% helped.

Cases with compensation—29.1% well and 50% helped.

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|---|---|
| Average cost to insurance carrier | $3188. |
| Ultimate award | $1040. |
| Average number of days lost | 350. |

These figures and our data add up to earlier recognition of the condition and earlier competent surgical treatment when the indications are clear.

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# ANESTHESIA IN OPERATIONS FOR RUPTURED INTERVERTEBRAL DISCS

The Author. *Howard W. Umstead, M.D., Chief of Anesthesia Service, The Memorial Hospital, Pawtucket, R. I.*

FROM THE ANESTHESIA VIEWPOINT the 18 cases discussed here today may be conveniently divided into a first group consisting of 12 cases and a second group of 6 cases.

The first group received either spinal anesthesia or endotracheal ether anesthesia depending upon the site of the lesion and the spinal fluid findings. In two cases with cervical lesions the obvious choice was endotracheal anesthesia. However, in the remaining 10 cases with lumbar discs, the selection of anesthetic technique invariably hinged upon the spinal fluid findings. The surgeon had requested that spinal anesthesia be omitted in any patient wih an appreciable elevation of spinal fluid protein or cells. It was deemed unwise to inject spinal anesthesia drugs into the subarachnoid space for fear of causing permanent damage to nerve roots already irritated by rupured discs. As a result of this policy only 3 of the 10 patients with lumbar lesions received spinal anesthesia and the remaining 7 operations were performed under endotracheal ether anesthesia.

Very early in our experience we became impressed with the superiority of spinal anesthesia for this type of surgery. The spinal cases, without exception, withstood the operation very well and showed no clinical evidence of shock. Such was not the case with patients receiving 2 or 3 hours of endotracheal ether. Some of these individuals presented evidence of mild or moderate degrees of shock in spite of careful attention to fluid replacement, blood replacement, and the other details of managing a patient under anesthesia. It is our belief that the prone position, so necessary for this operation, inteferes materially with normal respiratory chest movements in patients under general anesthesia. From the very start of this series we had considered this problem of respiratory restriction. Attempts were made to facilitate breathing by elevating the pelvis on sand-bags or by adopting a position somewhat between the lateral recumbent and the true prone position. With slender individuals a satisfactory position could usually be made; but, in obese patients, labored breathing was often present in spite of our best efforts. One may raise the question of respiratory inefficiency under spinal anesthesia. Without going into detail I think it is reasonable to assume that a conscious patient will take care of his own respiratory needs providing the spinal anesthesia is confined to the lower half of the body and adequate circulation is maintained to transport the respiratory gases. Heavy sedation, on the other hand, will tend to produce a situation similar to that which is present with general anesthesia. It is common knowledge that ether causes temporary derangement of function in various organs of the body, especially the liver and the kidneys. Although this factor is probably of minor importance in this series of cases, any deviation from normal physiology must be interpreted as distracting from the well being of the individual.

Last July we decided to try peridural anesthesia in an attempt to overcome our problem. This form of anesthesia has been used in the last 6 operations which comprise the second group of cases. The technique is essentially the same as was described here last year in a presentation of obstetrical anesthesia. In brief, the anesthetic solution is injected into a space just outside of the dura, the peridural space. The needle approach is made in the lumbar region two spinal segments above the suspected or known site of the ruptured disc. If continuous anesthesia is desired a ureteral catheter is inserted for subsequent injections of anesthetic solution. The continuous technique, with either 2% procaine or 1.5% metycaine, was used in 5 patients. In 2 of these cases moderately heavy sedation was required during the latter half of the operation because of restlessness and complaints of discomfort from the operative procedure. The other 3 cases did well with fractional peridural anesthesia. A number of questions arise if one attempts to explain these variable results but they cannot be adequately discussed at this time. The remaining patient of the second group of cases received a "one-shot" peridural anesthesia with 0.2% solution of pontocaine, — a longer acting anesthetic drug. This patient enjoyed complete comfort throughout the operation, muscular relaxation was excellent, and the situation was identical to the operative conditions seen with spinal anesthesia.

Obviously much more experience is needed to obtain the maximum benefits from peridural anesthesia in these patients. Such factors as strength of anesthetic solution, rate of injection, effects of gravity, and dosage require careful consideration. However, we do feel that progress is being made and our plans for the immediate future call for more peridural and less ether anesthesia.

A consideration of other forms of anesthesia has been purposely omitted because of the brief time allowed for this presentation.

# UNUSUAL COMPLICATION OF URETEROLITHOTOMY*

HARRY M. KECHIJIAN, M.D.

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THE PURPOSE of this paper is to report a case of ureteral diverticulum. This anomali has been variously described as a pouch or pocket leading off the ureter. In 1947, Culp, after a review of the literature, summarized 52 such cases. However, 37 of these reports were excluded, as they were found to conform to 5 main groups, namely, hydronephrosis, ureterocele, vesical diverticulum, blind-ending branches of bifid ureters, and segmental ureters. Fifteen cases were thus left, which came under the proper heading of ureteral diverticula. Ten of these were true congenital diverticula, while 5 were the acquired type. When the diverticulum is composed of all the layers normally found in a ureter, and when it communicates with the ureteral lumen through a distinct stoma, it is classified as being congenital. If it is the result of a protrusion of the mucous lining through the muscular coat of the ureteral wall, it is classified as being acquired. The acquired diverticulum may be a localized extravasation of urine at the site of a previous ureterolithotomy, or it may be a blow-out in the ureteral wall secondary to stricture, calculus, or trauma. Among these 5 reported cases of acquired ureteral diverticula, 2 were presented as having followed ureterolithotomy. Bugbee made his report in 1931, and Davis in 1939.

I wish to report such a diverticulum following ureterolithotomy. In January of this year, a white male, age 26, was admitted to the urological service complaining of severe pain in the left loin and abdomen, urgency, dysuria, and hematuria. X-rays revealed a few very small silent calculi in the lower calix of the right kidney. Also present was a small opaque calculus in the middle calix of the left kidney, and a large calculus was seen in the left ureter at the level of the third lumbar vertebra. This large stone was removed by operation. It was not deemed advisable at the time, to attempt going after the small stone higher up in the left kidney. The patient made an uneventful recovery, and was discharged on the 12th. post-operative day.

Four months later, this patient was re-admitted for a recurrence of the original symptoms, namely, pain in the left loin and abdomen, frequency, dysuria, and hematuria. White count was 28,500. Urine culture was positive for bacillus proteus. Blood chemistry normal. A flat plate of the abdomen revealed the previously mentioned small calculi in the right kidney. The small calculus formerly present in the middle calix of the left kidney must have been passed by the patient sometime during the intervening 4 months, as it could not be found.

A catheter was passed into the left ureter, and met with obstruction at a point just above the iliac crest. The x-ray revealed the tip of the ureteral catheter to have curled around on itself, making almost a complete loop. Skiodan injection then demonstrated that the tip was in a large ureteral diverticulum. A moderate degree of hydronephrosis and hydro-ureter was also present. Conservative treatment had to be discarded due to the persistent urinary infection, and because proper drainage of the dilated left kidney with a ureteral catheter could not be instituted. A surgical extirpation of the diverticulum was therefore performed. The patient made an uneventful recovery.

Four weeks later, re-check x-rays revealed no further evidence of the diverticulum, and although there was present some narrowing and angulation of the ureter at the operative site, kidney drainage seemed to be adequate. This was substantiated by the recent pyelograms taken only a few days ago, which show the remarkable improvement in the condition of the left kidney and ureter.

I would like to make a few suggestions that may be helpful in avoiding such a complication following ureterolithotomy: 1-Control of infection; urine cultures are helpful in determining the choice of urinary antiseptics to correct infection both pre and post-operatively. The pH of the urine if carefully checked and controlled will enhance the action of these drugs. 2—Ureteral splint; the use of an indwelling ureteral catheter of adequate size will act as a splint to hold the ureter in proper position. At the same time, it will promote healing by protecting the edges from coming in contact with infected urine. The less the infected urine seeps through the repaired area, the more remote will be the chances of periureteral fibrosis, stricure, hydronephrosis, and diverticulum formation. 3—Whenever possible, the ureteral incision should be closed with fine interrupted chromic catgut carried through the outer and middle coats, but not the mucosal layer.

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# SOME DIETARY FACTORS IN CARDIOVASCULAR DISEASES*

SAMUEL PROGER, M.D.

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DIETS in one form or another in the treatment of cardiovascular diseases are probably as old as the diseases themselves. The relatively modern era of diet therapy in this field, however, may be said to stem from Karell. Karell, who was a physician to the Russian Court almost a century ago, could have had little idea of the mechanisms by which his diet produced its undoubted beneficial effects, particularly in patients with cardiovascular diseases. But as so often happens in medicine, knowledge empirically acquired becomes knowledge scientifically substantiated.

The Karell diet, which consists of no more than 200 cc of skimmed milk four times daily, has at least five major attributes. It is low in calories, it is low in fluid, it is low in protein, it is low in sodium, and it is low in fat. It is these five attributes which constitute even today the principal bases for the dietary approach to the problems of cardiovascular disease. They will be separately discussed, the discussion being limited to a few points of practical importance in each category.

### *Low Calories*

Our knowledge of the physiologic effects of undernutrition stems chiefly from the classic experiments of Benedict and his co-workers during the first World War. Those experiments showed among other things that the heart rate was slowed, the blood pressure lowered, and the metabolic rate diminished following a period of several weeks of undernutrition with a loss of some 10 per cent of body weight. These and other effects of undernutrition were obviously desirable in patients with heart disease, as we were able to demonstrate in our own laboratories some 15 years ago. During the second World War, Ancel Keys and his co-workers repeated and confirmed Benedict's observations. Keys was sufficiently impressed with the effects of undernutrition on the circulation as to suggest that most, if not all, of the beneficial effects of the rice diet might be attributed to the weight loss which so often accompanies this diet. While simple undernutrition frequently results in a considerable drop in blood pressure with occasionally some decrease in the size of an enlarged heart, as all practitioners have had occasion to note, the dramatic changes following the rice diet which occur so frequently in the fundi, electrocardiogram and kidney function are indeed unusual following simple undernutrition. One must conclude that the benefits of the rice diet are more than can be attributed to simple weight loss. Be that as it may, a low caloric diet has an important and well-established place in the treatment of cardiovascular disease.

### *Low Fluid*

It is now well established that fluid restriction is not only unnecessary in cardiovascular disease but may actually be harmful if there is renal insufficiency. Only in recent years has it become widely recognized that fluid retention is related primarily to sodium retention and that if the sodium intake is sufficiently restricted, normal or even increased water intake is harmless. If there is impaired renal function, extra water is required to provide a larger urinary volume. This larger urinary volume is necessary for the excretion of substances which the kidneys are unable to concentrate into a smaller volume. Enough water should be given under these circumstances to produce a urine volume sufficient to remove the waste products. Schemm has suggested that a twenty-four-hour urine volume of about 1500 cc is desirable. It is probably rarely necessary to give more than 3000 cc for this purpose. Otherwise, in cardiovascular disease water may be given as desired.

### *Low Protein*

Except in the presence of renal insufficiency, a low protein intake has no apparent virtue. When there is renal insufficiency, however, a low protein intake may be of importance. A striking drop of the blood urea nitrogen from an abnormally high level has frequently been observed following a sharp restriction of protein intake. This is reasonable in view of the fact that it is only through the kidneys that the metabolic products of protein breakdown

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can be eliminated, and this elimination requires kidney work. It seems likely that the beneficial effect of a low protein diet in the presence of azotemia is more than a "laboratory improvement". Probably one of the most important contributions of the rice diet is the demonstration that a diet which contains only 15-20 grams of protein can be given almost indefinitely, at least for months. This is probably because of the at least partial sparing effect of the high carbohydrate content of this diet on the tissue breakdown of protein.

Kidney functional impairment is to a surprising degree reversible. It is common experience to have a patient in apparent terminal uremia make a partial recovery and remain reasonably well, perhaps for years. Even if rigid measures were required to bring about such a remission they would appear to be justified. It has been estimated that the daily protein intake which results in minimum kidney work is 0.2 gm per kilo of body weight. In the average adult this would mean an intake of about 15 gms of protein. But it appears that at least 20-25 gms of protein are necessary in order to maintain nitrogen equilibrium or to avoid endogenous tissue breakdown. Such a minimal intake would appear to be desirable at least in those conditions in which some degree of reversibility of impaired kidney function persists and until the reversibility has been achieved. Thereafter, kidney function may be sustained on a diet containing 0.5 gm of protein per kilo of body weight or some 35-40 gms of protein.

This should easily be enough to maintain nitrogen equilibrium even in the absence of a relatively high carbohydrate content. The situation so far as renal failure is concerned may in some respects be compared to that in congestive heart failure. Just as an incompetent heart can be restored to reasonably good function for a number of years by intensive therapeutic measures during the more severe stage of failure, with less strenuous measures thereafter, so too, functionally impaired kidneys may be restored through a relatively short period of rigid protein restriction with only moderate restriction for some time thereafter. The analogy may extend even further; just as moderate restriction of salt intake to 3-4 gms proves ineffective in severe congestive failure whereas restriction to about 1.0 gm proves very helpful, so moderate restriction of protein intake in renal insufficiency to 35-40 gms may be of little help whereas restriction to about 20 gms may prove more beneficial.

### *Low Salt*

We have heard much of late about the role of salt in cardiovascular disease; more particularly in hypertension and in congestive heart failure.

The role of salt in hypertension is not yet clear. An increase of salt intake does not elevate the blood pressure; salt restriction on the other hand, if extreme, appears to produce a lowering of blood pressure in some patients; it appears that the lowering of blood pressure directly attributable to sodium restriction is maintained only so long as the extreme sodium restriction is continued. The lowering effect on the blood pressure of even extreme salt restriction, however, is by no means regular, and the mechanism of the lowering is by no means clear. There are some who believe that the effectiveness of the rice diet in favorably influencing hypertension is due solely to the low salt content of this diet. It may be that the lowering of blood pressure which so often follows the rice diet may be largely a low salt effect. It is difficult, however, without more evidence, to believe that the striking lowering of the blood urea nitrogen from an abnormally high level and the dramatic clearing of neuro-retinitis, to mention just two examples of what may occasionally follow the institution of a rice diet, are the results simply of salt restriction. It is more likely that such benefits, which are in reality more important than the simple lowering of blood pressure, may result from some of the restrictions of the rice diet other than salt—the low protein content, for example.

A low salt intake is justifiable in hypertension only if there is evidence of cardiac weakness. Under these circumstances it is desirable, not for the lowering of blood pressure, but in order to aid in the prevention of the accumulation of fluid resulting from the cardiac weakness. In other words, cardiac weakness, not hypertension, is the indication for salt restriction. The question may be raised as to whether salt restriction may be prophylactically beneficial in hypertension, that is, whether it may be helpful in preventing cerebral accidents, heart failure, or renal insufficiency. There is certainly no evidence to favor such an assumption. Salt restriction might conceivably delay the appearance of signs of heart failure (fluid retention) in the presence of hypertension but one might just as rationally employ digitalis prophylactically for the same purpose. In fact, there is more justification for the prophylactic use of digitalis in hypertension both from a theoretical and, even more importantly, from a practical point of view since it is obviously much easier to take.

On the other hand if the occasional blood pressure lowering effect of a low salt intake could be maintained, it would certainly be desirable. In this connection, however, it is well to emphasize again two points. In the first place, the salt restriction must be extreme to be effective and this makes it difficult from a practical point of view. In the second place, the evidence thus far indicates that

*continued on next page*

just as soon as salt even in moderate quantities is permitted, the low salt effect on the hypertension is lost. It appears, therefore, that if salt restriction is to be employed in the treatment of hypertension, it must be extreme and permanent. It is questionable whether such a program is practically applicable, particularly since most patients with hypertension live a relatively long and asymptomatic life so far as their hypertension is concerned. Under the circumstances, it is not unlikely that the present enthusiasm for the use of salt restriction in hypertension per se will quickly wane.

In congestive heart failure the role of salt restriction is well established. In order to have congestive heart failure one must have congestion and in order to have congestion one must have excessive fluid retention and in order to have excessive fluid retention one must have salt retention, that is, a positive salt balance.

Obviously, a restricted intake of salt will make more difficult a positive salt balance or salt retention. It is the salt retention which is crucial. It is possible that we have tended to think too much in terms of restriction of salt intake and not sufficiently in terms of salt retention. Salt intake is important only as it relates to salt retention. In the presence of severe congestive heart failure a maximal restriction of salt intake is necessary in order to assure little or no salt retention. With less evidence of heart failure this becomes less true; that is to say, a patient in severe congestive failure may be able to avoid a positive salt balance or some salt retention only if his intake is one gram or thereabouts. However, with little or no evidence of failure, present or recent, he may have no salt retention with an intake of 2-3 grams. In fact, patients with heart disease but without recent heart failure often seem to be able to tolerate a normal or moderate salt intake quite well, that is, without any retention, just as patients who have been severely dyspneic on even the slightest exertion may after a period of active therapy for the severe failure come to perform moderate physical exertion with complete comfort.

From the practical therapeutic point of view this is of some importance. It is psychologically undesirable and perhaps clinically impossible to institute extreme physical limitations throughout the years which may follow a period of severe congestive failure. It is indeed unnecessary. Perhaps it is equally unnecessary, undesirable, and impractical to employ too stringent salt restriction during the prolonged periods of relative cardiac competency which usually follow a period of well-treated congestive failure. Incidentally such an approach may be helpful in preventing some of the unnecessary deaths from excessive loss of salt, which are being reported with increasing frequency, resulting from the too enthusiastic and prolonged adherence to extreme salt restriction plus frequent mercurial diuretics.

### *Low Fat*

There is much of interest in the current attempts to relate coronary atheromatosis to the increased ingestion of fats and sterols, particularly cholesterol. It appears that there is a high incidence of atheromatosis in people whose diets are rich in animal fats and hence cholesterol, whereas atheromatosis is relatively rare in those who subsist on a low fat, low cholesterol diet.

Also, some believe that there is an increased incidence of atheromatosis in conditions associated with hypercholesterolemia such as diabetes mellitus, myxedema, nephrosis, and essential xanthomatosis.

But the problem of lipids and atheromatosis involves much more than cholesterol ingestion and blood levels. The cholesterol factor must be thought of in terms of (1) ingestion, (2) absorption, (3) synthesis, (4) deposition, and (5) removal. As to ingestion, the evidence indicates that simple restriction of cholesterol intake has very little effect on the blood level of cholesterol. The total fat intake is important, however, in this regard. An extreme restriction of fat intake is quite regularly followed by a lowering of blood cholesterol. But the restriction of fat must be extreme such as, for example, the approximately 5 gms of fat content in the rice diet. The extremely low fat intake is effective in lowering blood cholesterol for several reasons. In the first place, the cholesterol intake is decreased (this alone is ineffective as mentioned above); second, the absorption of cholesterol, since it occurs only in the presence of fat, is hindered; and third the intestinal reabsorption of the cholesterol excreted in the bile is largely prevented because the flow of bile into the intestinal tract is decreased as a result of the low fat intake.

There are other factors involved in cholesterol absorption, such as enzymes (lipases) and phosphorylative mechanisms, which also may play a role in determining how much of the ingested cholesterol or bile cholesterol may actually be utilized.

The cholesterol problem is complicated further by the fact that cholesterol is synthesized in the body (largely if not entirely in the liver) so that there is an endogenous as well as an exogenous factor to contend with. The relative importance of exogenous and endogenous cholesterol in respect to atheromatosis is most obscure and this obscurity tends further to make therapeutic considerations more complex.

Then there is the problem of cholesterol deposition in the blood vessels. Cholesterol esters having reached the circulating blood must somehow be

deposited in the atheromatous lesions where they are regularly found. The mechanisms by which cholesterol appears in various parts of the vessel walls are probably multiple, and the current explanations are still largely theoretical. The factor of cholesterol deposition in the vessel wall constitutes a major phase of the total cholesterol-atheromatosis problem and may present an important area for therapeutic efforts.

The same may be said regarding cholesterol removal from the vessel walls since there is evidence to suggest that atheromatous lesions, especially the early ones, are reversible.

These sketchy comments on the role of cholesterol in atheromatosis may serve at least to indicate first that the problem is complex, and second, that it is much too early to regard seriously present therapeutic efforts for the dietary control of atheromatosis. It is possible that an extremely low fat intake, indefinitely prolonged, might check the development of atheromata but since such a procedure is hardly practicable we shall have to await a more satisfactory approach to the problem.

Dietary factors are of practical importance in the management of many phases of cardiovascular disease and they will continue to be until more specific agents are available. In the final analysis the function of tissues is dependent upon the oxygen and food substances which reach them. We may not be able to influence greatly the oxygen supply which reaches these tissues but we can exert some influence over the other substances necessary for proper tissue function. Whether or not this latter influence will be favorable will depend to a considerable extent upon whether or not the dietary management is wise.

### *Conclusions*

(1) Caloric restriction has important beneficial hemodynamic effects in patients with heart disease quite apart from the lightening of the body mass which needs to be transported.

(2) Water need not be restricted in the presence of a low salt intake. When there is renal insufficiency, fluids should be forced generally to about 3000 cc or the fluid intake should be sufficient to produce a twenty-four hour urine volume of about 1500 cc.

(3) Extreme restriction of protein intake to about 20 gms is desirable in the presence of renal insufficiency with an elevated blood urea nitrogen. When and if this proves effective in lowering the blood urea nitrogen a more moderate restriction to about 35-40 gms may be continued indefinitely. There is often a remarkable degree of reversibility in renal insufficiency.

(4) Low salt intake appears to be effective occasionally in lowering blood pressure. However, the intake must be extremely low and it must be continuous. It is questionable whether salt restriction is of practical value in the treatment of hypertension as such.

(5) In patients with heart disease extreme salt restriction is necessary only so long as there is evidence of congestive failure. Thereafter only moderate restriction is necessary.

(6) The relationship of dietary fat and cholesterol to atheromatosis is complex. One is not justified in placing undue emphasis upon the importance of the dietary restriction of cholesterol in the light of the available evidence.

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### RECENT TRENDS IN SURGERY OF THE THORAX

*concluded from page 377*

We have had two hopelessly inoperable cases in which there has been a dramatic response from nitrogen mustard therapy. This substance although most beneficial in patients with malignant lymphoma appears to have definite value as a palliative measure in the highly undifferentiated carcinomas.

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# The RHODE ISLAND MEDICAL JOURNAL

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## CONGRATULATIONS TO BROWN

We suppose that in the early days of Brown University most of the Governing Board were ministers. That was not remarkable. For centuries, members of the cloth have taken an active personal part in the duties of government. During the last century business men and lawyers began to replace them. We have not made a count but we have a definite feeling that lawyers now predominate. An university ought to be pretty careful about this.

Dr. Pritchett, at that time head of the Carnegie Foundation, said that the great trouble with the government in the United States was that it was given over largely to the legal profession. If we remember his argument, it was that by the very nature of their work lawyers were special pleaders. When a client came to them it was not for them to find out what was right and just in the case; it was their duty to convince the courts that right was on their client's side.

It has seemed to be a feeling of big business men that their success was an evidence of an all-around philosophical ability. Consider Henry Ford; he got several new ideas and pushed them until he was worth millions or billions. He frequently gave evidence that he considered himself as a philosopher.

Physicians have never fallen into these pitfalls. They are only too sadly aware, as they try to interpret disease and the complexity of human life, that they must not take a definite stand and then try to fit facts to this. They must always follow the facts, no matter how their earlier opinions are made to appear ridiculous. Pliability of mind thus developed should be invaluable in education.

Not long after the Civil War, Dr. W. W. Keen became a member of the Governing Board of Brown. He served for many, many years with tremendous enthusiasm, fidelity, and we believe, wisdom. One might have thought that this would encourage the University to use more of his ilk. How did they respond to this? Years after Dr. Keen had ended his remarkably long services, Dr. Marshall Fulton received a short interim term of three years. That, so far as we know, is all the use that the University has made of one of the great learned professions in administering their educational enterprise.

The Alumni have chosen Cary Bumpus, one of the outstanding physicians of the country, to serve as a trustee. If he maintains good behavior, the University will now have the services of an M.D. for six years. Perhaps the prestige of his eminent father, whose great career in education at Brown

and other institutions is well-known to us all, influenced the decision.

The Governing Board is largely a self perpetuating institution. Let us hope that they will broaden their vision and occasionally take measures themselves to use the qualities peculiar to the medical profession.

## DR. WOOLWORTH, OPHTHALMOLOGIST

The London Lancet of April thirtieth has a reassuring editorial for the beneficiaries of the British Health Bureau. As you know, the government pulls medicines out of a hat and presents them free of charge to patients. (Taxes are tremendous in Britain.) It has also been decided that reading glasses are medicine. Practically every adult has some imperfection in his optical apparatus.

We all want anything we can get for nothing. So everybody in Britain is having a "free" eye examination. There is always a correction found so everybody orders "free" glasses. The result is that when one with a serious defect of vision shatters his glasses he is told "It will take three months" for new ones, which "can seem like a sentence to three months inside a personal fog bank."

But there are compensations, the Lancet finds, for British medicine. "There seems to be no evidence that glasses bought from a tray, whether in Woolworth's, or elsewhere, do any damage." We have no doubt, knowing American business acumen, that Woolworth has seen the "inevitable" coming in American Medicine and that the Corning Glass Works are already turning out lenses by the million for them. And the clever young girl who caught the goldfish when we stocked the aquarium undoubtedly possesses the minor skill necessary for fitting.

The Lancet however has to show a little British gloom as it points out that "glasses bought from a tray always give the same correction for each eye; if the chooser needs different corrections he cannot be fitted satisfactorily." Of course the rare fellow whose eye disturbances are due to glaucoma is just out of luck.

## DIPLOMATES FROM NEW ENGLAND SCHOOLS

The five medical schools in New England claim almost two sevenths of all the physicians who attained the rating of Diplomates by the end of 1948. A compilation of the Diplomates from the country's seventy-nine medical schools showed a total of 18,463 of whom 5,012 were trained at New England institutions.

The breakdown by schools shows Harvard with 2,023 diplomates, Tufts with 1,222, Yale with 781, Boston University with 676, and the University of Vermont with 310.

## RHODE ISLANDERS HONORED

At the first Bi-Annual meeting of the American Academy of Neurology, held at French Lick Springs, Indiana, early in June, Mrs. William N. Hughes, president of the Woman's Auxiliary of the Rhode Island Medical Society, was elected for a two year term as the first President of the Woman's Auxiliary to the American Academy of Neurology. And at Hot Springs, late in May, the American Dermatological Association, rated the highest ranking group of dermatologists in the country, elected Dr. Francesco Ronchese to its membership. At Atlantic City, the day prior to the opening of the AMA session, the Conference of Presidents and Other Officers of State Medical Associations re-elected our executive secretary, John E. Farrell, as its secretary-treasurer.

The Journal salutes, in behalf of the Society, these Rhode Islanders for their distinguished work which has brought to them and to us added honor.



## WOMAN'S AUXILIARY

Delegates to National Meeting:

*Presidential Delegate*:
Mrs. William Newton Hughes

*Delegates*:
Mrs. Charles J. Ashworth
Mrs. Jesse P. Eddy, 3rd
Mrs. Charles L. Farrell

*Alternate Delegates*:
Mrs. J. Murray Beardsley
Mrs. Robert T. Henry
Mrs. Daniel V. Troppoli

NOMINATING COMMITTEE 1949-1950:
Mrs. H. Lorenzo Emidy
Mrs. J. Murray Beardsley
Mrs. Martin O. Grimes
Mrs. Henry J. Hanley
Mrs. Arthur E. Hardy
Mrs. H. Frederick Stephens
Mrs. William H. Tully, Jr.

# NATIONAL HEALTH PLANS — BRITISH AND AMERICAN*

ROBERT E. S. YOUNG, M.D.

The Author. *Robert E. S. Young, M.D., of Columbus, Ohio. President, American Association of Physicians and Surgeons; Instructor in Surgery, and Assistant Professor of Preventive Medicine, Ohio State University Medical School; U. S. Delegate to the 9th International Congress on Industrial Medicine, at London, 1948.*

PHYSICIANS since the founding of our Republic have been primarily interested in the health of our citizens. For years, Medical Associations have appointed commissions and committees to study, make recommendations and to sponsor legislation at the local, state and National levels. To this end great and steady progress has been made. It is true Medical Associations have often opposed various plans for medical care and later have become sponsors of such plans. It is equally true that this change in attitude did not occur until acceptable changes had been made in the envisioned plans. This is called a "negative attitude" by those with whom we do not agree, *so might we designate the attitude of those who do not agree with organized medicine.* It is fundamental that no sound advances will ever be made without a questioning attitude.

This statement of the interests of the medical profession should be entirely unnecessary. However there are those who find it in their interest to discredit the profession and for this purpose place grave charges against us, opening the way for the statement, "I see no possible way to provide funds needed for adequate medical services to these between groups, who constitute the vast majority of our people, except through a system of national health insurance."[1]

Let us critically examine a few of these charges: The Federal Security Administrator states that every year 325,000 people die whom we have the knowledge and the skill to save.[2] Forty thousand of these die from accident. How many accidents would Compulsory Health Insurance prevent? As this statement is made without supporting data, one would like to know the ages of these people, whether or not they were under a doctor's care at the time of death. We all know that people do not live for ever. We all know that except for sudden death, virtually all are under a physician's care at the time of death. Can compulsory health insurance change this picture for the better?

Every year, the Nation loses $27,000,000,000 in national wealth through sickness, and partial and total disability.[3] Are the proponents of Compulsory Health Insurance suggesting that these losses will be eliminated under National Compulsory Health Insurance? Let us look at previous experience. Germany sickness rates went up with the compulsory health system. The average lost time from sickness rose from 14.1 days in 1885 to 29.3 days in 1932. We must then conclude that under the proposed compulsory health insurance bill the cost in national wealth would eventually double.

### *Misuse of Draft Statistics*

Further the proponents say "The record of Selective Service examinations during the war is widely known—5,000,000 men declared unfit physically or mentally for the armed services of their country."[4]

Yet Maurice Friedman[5] testifying before the Committee on Labor and Public Welfare, United States Senate, Eightieth Congress, presented an analysis of the draft statistics and showed that:
1. 2.7 million men enlisted voluntarily and those rejected fell back to be drafted and their subsequent rejection in the draft swelled this figure percentage wise.
2. The causes for rejection for the most part were beyond the province of medical care—such as illiteracy, congenital anomalies, diseases which in the light of our present knowledge are neither preventable nor remediable. Dr. Friedman ended with this statement: "20% of rejections in period A and 18% of rejections in period B might have been influenced by medical care but in order to obtain such figures we must assume that (1) every person with such abnormality would have sought medical attention (2) that the physician in charge would have recommended corrective measures, including major surgery, in each instance (3) that

*Presented before the 138th Annual Meeting of the Rhode Island Medical Society, at Providence, May 11, 1949.

the patient would have accepted the recommendation and (4) that the recommended procedures would have been 100% effective in every instance."

We are left with the proposition that the continued misuse of draft statistics is pure propaganda.

The Proponents say that 68,000,000 persons in the U. S. are without adequate medical care. This statement is apparently based upon the fact that these are wage earners not covered by Compulsory Health Insurance. It completely ignores the 52,584,000 individuals protected by some form of voluntary hospital, surgical and medical expense insurance.[6] It completely ignores the service rendered by private practice, which led to the findings of the Brookings Institution—in short—"Probably no great nation in the world has among its white population better health than prevails in the United States."[7]

Recently the proponents have attempted to brand the educational activities of the AMA as a lobby with a $3.5 million "slush fund." Yet the Third Intermediate Report of the Committee on Expenditures in the Executive Departments, 80th Congress, House Report No. 786 points out that—The United States Public Health Service. The Children's Bureau, The Office of Education, The United States Employment Service, The Department of Agriculture, and The Bureau of Research and Statistics, Social Security Board employed 45,000 people and spent $75,000,000 out of federal funds for socialized medicine propaganda in 1946 alone.[8] Medicine must depend upon a host of voluntary workers within and without of the profession if a free profession in a free America is to survive.

The Proponents say—"There is a shortage of doctors and compulsory Health Insurance will solve the shortage. At present the public enjoys a ratio of 1 doctor to every 790 people. The word shortage is an implement of comparison. With what then shall we compare our present number of physicians? With the situation abroad?

The British Medical Association estimates that in England there is one practicing physician for every 2000 people.[9] All other nations including some 35 having government controlled medicine fall below this average. Would the past record in the U. S. be illumination? There has been a steady increase in the ratio of physicians to population. Since 1940 the population has increased 12% and the number of physicians has increased 14%.[10] We are on the eve of a great proportionate increase. There are 6 new medical schools in the process of organization and 6 more schools are adding the last 2 years to their curricula. Virtually all medical schools and teaching hospitals are in the process of expansion. Doubtless every physician in this room could care for a few more patients if they sought treatment. Where is the shortage of which the proponent speaks?

The Proponent speaks of a shortage of hospitals, "1200 counties in the U. S. are without a hospital." Examination shows that 1187 are within 30 miles of a general hospital. Of the 13 without hospitals the population is insufficient to support one.[11]

One can go through, "The Nation's Health" a report to the President by the Federal Security Administrator and similar propaganda releases and discover that critical scrutiny develops a vastly different picture. It is needless to proceed further along this course. One is faced with the premise that the campaign to discredit the profession is not based upon fact, but on the contrary, represents the best effort to date to create a synthetic demand for a change in our conception of medical practice.

The story of the creation of this artificial demand and the people and powers behind it is well known and has long since been established and documented.[12] One's choice in this consideration is based upon one's political philosophy. I do not propose to engage in this phase of Compulsory Insurance although it is intensely important.

### *Efficiency, Energy and Intelligence Factors*

My approach to the problem of National Compulsory Health Insurance is based upon this premise:—Regardless of one's political philosophy the standard of living enjoyed by the people of the United States is dependent upon efficiency with which we produce and the energy and intelligence we put into our labors. Waste of personnel, money and effort will be reflected in a lower standard of living. If such waste is large, the impact will be great. This principle can be applied to the methods we employ or may employ in rendering health services.

Senator Murray has said, "Compulsory Health Insurance is as American as Pumpkin Pie"—let us look at our American Experience.

Although health insurance has been largely a European experiment, no small data has been accumulated in the United States.[13] Some seventy odd medical associations have engaged in health insurance plans of various sorts; Commercial Ins. Co., Labor unions, employers, fraternal organizations, farm groups and even the Federal Government have experiences to offer.

Let us start with a brief analysis of the Michigan Medical Service Plan as our entree to American Experience. As it is an experiment large enough to be significant, having soon after its origin reached 500,000 subscribers and eventually attained greater than 1,000,000 subscribers. The original Michigan Medical Service Plan is of vast importance also because it is the miniature of the plan suggested by the President as a pattern for the nation.

*continued on next page*

Under this plan doctors were to give complete medical service in the home, office and hospital. Subscribers were to pay monthly premiums into a fund. Physicians were to submit monthly statements for their total work according to a fee schedule. If the fund was insufficient the payments to physicians were to be made upon a pro-rata basis. The Michigan Medical Association felt that $2.00 per person per month would be a sufficient premium. They placed the premium at $4.50 so that a reserve might be quickly built up.

Strangely enough very little change occurs in this sort of a plan for the first 6 months. After people get accustomed to it however, things begin to happen. Medicine is now "free." Within a short time under all similar plans here and abroad the demand for service increases. All Medical Association, labor unions, employer, fraternal, and Federal Farm Security Medical Service Plans offering complete comprehensive service show an average immediate increase of four times the previous service. The average continues up from there. Within a short time in Michigan cost had risen to $10.00 per person per month. Patients were making free use of free service.

Payments were made on a pro-rata basis and doctor bills were cut. The physician then realized that in order to stay at a fixed income level he would be forced to see more patients. The physician was placed in a position which made it to his economic advantage for his patients to abuse the plan.

Labor leaders as co-sponsors of the plan urged their membership to further abuses. It is said that in the blackest period, entire families had tonsillectomies—entire families even had appendectomies. Surgery rose to 3 times the original frequency.

### *Summary of Michigan Experience*

Out of this chaos certain things became evident. a) House calls, office calls and small services were not insurable risks and could be abused to infinity. b) The administrative cost of the office call was high (in some Plans it has risen to 60 to 70c out of the premium dollar).



c) The surgical, obstetrical and some medical benefits are abused but approximate insurable risks. The administrative cost is small—falling as low as 4-6c per premium dollar. Thus the patient will end up with more money if he pays his $2.00 office call with out bearing the administrative cost, and he will cheaply protect himself against catastrophy if he insures against the large medical expenses.

The Michigan Medical Service after pioneering this plan and rolling up a tremendous deficit had the courage to cut back its service to include the uninsurable costly small services and to retain the desirable high cost services. Since then the Michigan plan has changed its deficit into a surplus and is completely sound.

Other completely comprehensive plans over the nation have had the same experience and have reacted in one of four ways when faced with bankruptcy.[14]

(1) They may liquidate as did the San Diego Plan when costs reached $12.50.

(2) They may be subsidized (as the Kaiser plan was, out of excess-profits tax money during the war.)

(3) They may hold down costs by destroying the doctor-patient relationship and make the doctor an agent for policing the plan and combine this feature with a production line system of symptomatic treatment as is done in some employer and labor plans.

(4) They may cut back from comprehensive service to a sound insurance basis which in effect is cash indemnity.

These conclusions are based upon the experiences of Medical Associations which have pioneered in providing sound medical insurance for the low and middle income groups. The Blue print of National Compulsory Health Insurance has been tried and found wanting.

### *The Problem at National Level*

Let us then recall lessons learned at the local as we move to the national level.

The Federal Security Administrator says the proposed plan will work just as the present system of medicine works only the government will pick up the bill. There will be no disturbance of the doctor-patient relationship. The doctor will receive a fee for service and will be assured of payment.

What have we learned from our American Experience? Within the first 6 months there is an increased demand for service reaching 4 times the previous level. Private Medical care in 1947 cost $8,500,000,000.[15] We may guess with considerable authority that the touted National Compulsory Health Plan will cost $34,000,000,000 per year. When one considers that our present national budget is $39,000,000,000 the estimate of medical cost is shocking.

*continued on page* 392

## NATIONAL HEALTH PLANS— BRITISH AND AMERICAN

*continued from page 390*

The Federal Security Administrator says that the cost would be met by 3% of payrolls or 3% of $230,000,000,000[16] or $6,900,000,000. The Treasury Department and the actuarial research divisions of some of our large insurance companies estimated the cost at 20% to 25% of payrolls which closely approximates my guess based on our American Experience.

New Zealand adopted a plan almost identical to the proposed National Compulsory Health plan in 1938 and after 5 years of operation it was absorbing 40% of the total tax revenue of New Zealand.[17]

It must be obvious to all that this type of plan would go down under a mass of abuses and crushing costs. Controls would be necessary.

Inasmuch as cost is of primary concern the first step would be a change from a fee basis to the panel or per capita payment system. This is the system which is in operation in Great Britain now. The doctor is paid a set amount each year for service to each patient on his panel. Theoretically, by multiplying the per capita payment by the number of the total population the total cost of the plan can be predicted and fit into a national budget.

### *The British System*

On July 5, 1948 it was predicted that the cost of the British National Health Service would be $400,000,000 per year; by September the estimate had risen to $600,000,000; by December to $1,200,000,000. How can this be? Let's look in the doctor's office for the answer.

As volume increases the doctor uses the simplest device for moving patients. Each patient is given a prescription or a packet of pills for symptomatic relief. This precludes examination, ends discussion and the line is kept in motion. This has resulted in soaring and unpredicted drug bills. The patient who needs other than symptomatic care is hospitalized. This has already resulted in a tremendous increase in demand for hospitalization in Great Britain. In New Zealand the demand rose to a point where 12½% of the population was hospitalized.[18]

We have learned from our American Experience that there is very little change in volume for the first 6 months; then the curve starts upward very abruptly. Great Britain has not felt the impact of her system as yet—wait two more years to see a vastly different picture.

The changes that will take place in Great Britain are matters of history in other nations that have been operating under government medicine for longer periods. All nations start their planning with a system similar to our proposed plan for National Compulsory Health Insurance. They step down to the panel system and by a system of controls attempt to make it work. Already in Great Britain there are some 2000 laws and rules[19] governing their health system. They will eventually be forced, as Germany was, into an area—salary system with strict limitation of service, facilities and drugs. In Germany the rules and regulations prior to World War II reached the stage where they were measured not by number but by volume, until Sulsbach[20] stated, "There is no longer a single specialist in Germany who knows even superficially the principal features of social insurance."

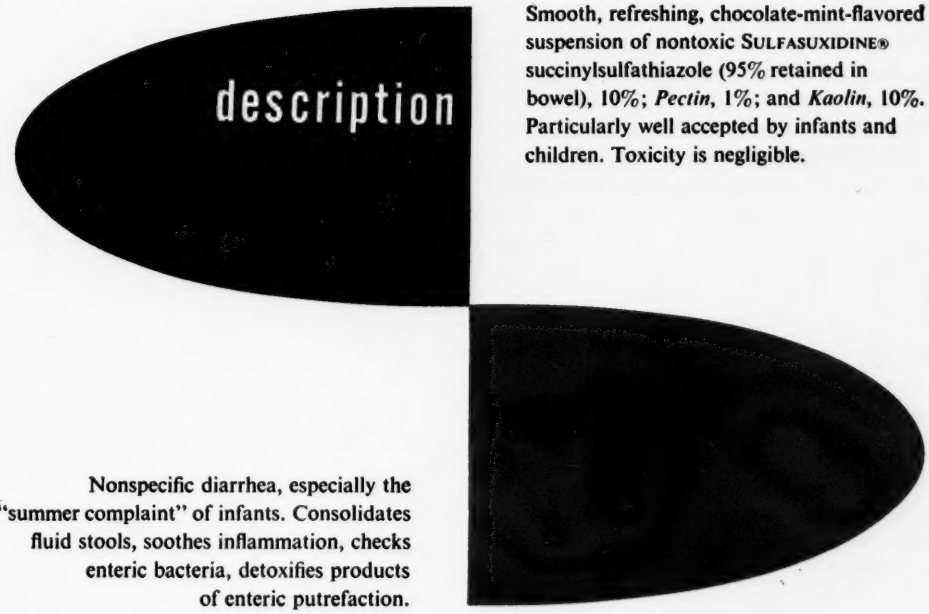
Medical Insurance by compulsive means, by limitation and prostitution of service can be forced into a less expensive pattern.

However, once the cost has been established and tax has been levied to pay for health insurance, the lowered cost is never reflected back to the people. *Health Insurance then becomes an easy, popular way to collect taxes.* In Germany, Hitler built the entire air force out of Health Insurance Funds.

You may say that this will not happen here. That in America we will safeguard our funds. Let us reflect for a moment that the Social Security Funds have been currently used for general government expense and a government I. O. U. placed to their credit. When it becomes necessary to make payment to our population reaching 65 years of age, this payment will be made out of current revenues—in short we will be taxed for it a second time. It has lately been suggested that the federal government use the I. O. U.'s in the Social Security fund as security for further government projects. This is a refinement—other nations have plundered their Health Insurance Funds, but we in America are devising a method by which they could be spent three times.

The history of "free" medicine both in America and abroad shows in unmistakable perspective how

*continued on page 394*


description
Smooth, refreshing, chocolate-mint-flavored suspension of nontoxic SULFASUXIDINE® succinylsulfathiazole (95% retained in bowel), 10%; *Pectin*, 1%; and *Kaolin*, 10%. Particularly well accepted by infants and children. Toxicity is negligible.
Nonspecific diarrhea, especially the "summer complaint" of infants. Consolidates fluid stools, soothes inflammation, checks enteric bacteria, detoxifies products of enteric putrefaction.
cremosuxidine®
Sulfasuxidine® suspension with pectin and kaolin
dosage
Infants: 2-3 teaspoonfuls, 4 times daily.
Children: 1-2 tablespoonfuls, 4 times daily.
Adults: 2-3 tablespoonfuls, 4 times daily.
Supplied in 16 fl. oz. *Spasaver®* bottles.
Sharp & Dohme, Philadelphia 1, Pa.
SHARP & DOHME

## NATIONAL HEALTH PLANS— BRITISH AND AMERICAN

*continued from page 392*

human frailty, the burden of mounting costs and control, the boredom and waste of impersonal endeavor can combine to produce a step by step degeneration of the laudable aims of governmental medicine.

### *Duty of American Medicine*

It is the duty of the American Medical profession to lend every effort to protect the American public from a system of Medicine which we have learned through experience to be contrary to the public good. The odds may seem to be overwhelming, but let us remember that often the difference between success and failure is almost immeasurable. The trend toward state socialism is strong, but in nations which have assumed a socialistic form of government a shift to the right is becoming evident.

Great progress has been made in post war recovery in Belgium, The Netherlands, Western Germany and Switzerland. France in recent weeks has admitted the inability of her government to operate certain industries and is turning the automobile industry back to private hands, and has indicated certain other heavy industries, banks, insurance and mines that are to be desocialized.



The recent Bourough Council Elections show that Socialism is losing strength in Britain. Ours is not a lost cause. Both Bismarck and Lenin have stated that Socialized Medicine is the key stone in the structure of socialism and communism. Let us fight the battle out on this front.

How are we to fight? First; Let us give our complete support to AMA campaign for better public relations. Not only pay your assessment but get out and work. Between 3 and 4 million people visit and talk to the physicians of America each day.

Tell the Story of American Medicine! You have a great story to tell. Learn the answers to the false charges and faulty statistics that are presented by our opponents. Don't be disturbed because American Medicine is not perfect. It will never be perfect under any system, but under a system of freedom it is better today than 10 years ago. It will be better 10 years from now than it is today. It is vastly better than it would be under socialized medicine. Strong attack in this sector is our first order. Secondly; Let us view the problem with considerable realism. For some 30 odd years bills for socialized medicine have been contemplated or introduced into our Congress. These bills have not gained the approval or support of the physicians of America. The Medical profession has not been called for expert opinion in the drafting of such measures.

There were 88 bills introduced in the 80th Congress that had a bearing on health in addition to the National Compulsory Health Insurance Bill. In the present Congress apparently this figure will be exceeded. Great pressure will be brought to bear to pass the over-all plan. Some of the lesser plans will be enacted into law.

It must be perfectly obvious that we may be taken by passage of the over-all bill or by enacting it slowly, piece-meal fashion. A collective threat must be met by collective action.

### *AAPS Plan of Non-Participation*

The second line of defense must be the AAPS plan of non-participation. This is a fundamental bargaining principle and we are in a bargaining position.

This is not a proposed strike. It is merely refusal of physicians to enter into any scheme of rendering health services which is contrary to the public good. They would continue to give service to patients as private patients under a system of free enterprise.

The effect of non-participation upon our lawmakers, according to several senators, would be the placement of increasing valuation on expert medical opinion. At present the experience of the profession is either entirely overlooked or discredited.

*continued on page 397*

## NATIONAL HEALTH PLANS— BRITISH AND AMERICAN

*concluded from page 394*

Non-participation has been used very effectively in Great Britain. By the threat of non-participation British physicians doubled their income under the plan and very largely modified ten unfavorable provisions of the Act.[21]

Non-participation has been very effectively used in British Columbia in forestalling a compulsory health plan.

Non-participation has been used very effectually by physicians in San Francisco against the Health Service System.[22]

Non-participation has been used effectively on the continent of Europe by physicians in virtually every nation.

*As successful diplomacy is bolstered by force so also does diplomacy without backing end in appeasement.* The AMA program for public enlightenment can be well supplemented by a front of AAPS non-participation.


[1] Ewing, Oscar R., The Nation's Health, a report to The President, Page XI.
[2] as above, Page 1.
[3] as above, Page 1.
[4] as above, Page 1.
[5] Friedman, Maurice H., Statement to The Committee on Labor and Public Welfare, United States Senate, 80th Congress.
[6] Eastern Underwriter, New A. & H. Survey Shows 52 Million Voluntarily Insured, 50:1. January 7, 1949.
[7] Medical Care For The Individual, A Study by the Brookings Institution. Made at the Request of Senator H. Alexander Smith, Chairman of the Sub-committee on Health, of the Committee on Labor and Public Welfare.
[8] Investigation of the Participation of Federal Officials in the Formation and Operation of Health Workshops., Third Intermediate Report of the Committee on Expenditures in the Executive Depts., 80th. Congress, 1st. session; House Report No. 786.
[9] The National Health Service Act. by The British Medical Ass'n.
[10] DeTar, J. S., M.D., The Present National Crisis.
[11] Ewing, Oscar R., The Nation's Health, a report to the President.
[12] Shearon, Marjorie, Blueprint for the Nationalization of Medicine, 1947.
[13] Young, Robert E. S., A Review of Medical Plans, 1943.
[14] Young, Robert E. S., Journal of Tennessee State Med. Ass'n. Oct. 1944. Page 169.
[15] Ewing, Oscar R., The Nation's Health, a report to The President.
[16] Ewing, Oscar R., The Nation's Health, a report to the President.
[17] Shearon, Marjorie, Socialized Medicine, Volume 1. No. 2.
[18] Jones, A. Lexington., Government Medicine in New Zealand.
[19] Shearon, Marjorie, Testimony before the Health Subcommittee of the Senate Committee on Labor & Public Welfare. Jan. 30, 1948.
[20] Sulzback, Walter, German Experience with Social Insurance.
[21] Young, Robert E. S., Socialistic Medicine in England. Connecticut State Medical Journal Jan. 1949.
[22] Williams, Greer, The Patient's Dilemma, Nation's Business, March 1949.

# ANNUAL REPORTS—1948

## THE RHODE ISLAND MEDICAL SOCIETY

### REPORT OF THE TREASURER

**Fiscal Year, 1948**

| | | |
|---|---|---|
| Receipts, 1948 (Exhibit A) | $34,845.47 | |
| Expenses, 1948 (Exhibit B) | $28,860.87 | |
| Surplus | $ 5,984.60 | |
| General Fund, Cash on Deposit, January 1, 1948 | $ 8,936.43 | |
| Accrued Surplus | $14,921.03 | |
| Investments, 1948, Government Bonds | $ 3,000.00 | |
| General Fund, Cash on deposit, January 1, 1949 | $11,921.03 | $11,921.03 |
| Cash in General Fund Credited to Special Funds (Exhibit C) | $ 1,850.04 | |
| General Operating Fund (Cash) | $10,070.99 | |
| * * * * | | |
| Invested Funds, January 1, 1949, U. S. Treasury Securities | | $ 5,000.00 |
| TOTAL ASSETS, January 1, 1949 | | $16,921.03 |

*Exhibit A*

### RECEIPTS, 1948

| | |
|---|---|
| Annual Dinner Payments | $ 1,325.00 |
| Cancer Conference Dinner | 288.00 |
| Council payment by members for dinners at meetings | 189.00 |
| Dividends from investments | 633.80 |
| Donations | 610.00 |
| Dues from Members | 26,894.30 |
| Endowment Fund, Sale of 16 shares of National Bank of Commerce stock. Cash balance after reinvestment | 159.52 |
| Exhibits, balance for 1948 meeting | 1,139.50 |
| Exhibits, deposits for 1949 meeting | 1,350.00 |
| Miscellaneous | 59.79 |
| Providence Medical Association | 2,196.56 |
| TOTAL | $34,845.47 |

*Exhibit B*

### EXPENSES, 1948

| | |
|---|---|
| Annual Meeting (including dinner payments) | $ 2,650.61 |
| Books | 221.53 |
| Cancer Conference | 384.53 |
| Committees | 1,029.52 |
| Delegates to A M A House of Delegates meetings | 413.54 |
| Donations and Dues | 151.50 |
| Electricity | 63.15 |
| Fuel | 827.50 |
| Gas | 45.08 |
| Insurance (Fire, liability, property damage, annuity) | 1,276.12 |
| Legal | 484.67 |
| Library (miscellaneous) | 233.39 |
| Mid-winter meeting | 42.88 |
| Miscellaneous (Society and executive office) | 737.96 |
| Office supplies and equipment | 857.59 |
| Postage | 386.14 |
| Printing | 1,023.87 |
| Repairs to Library (including new lights, painting, etc.) | 1,000.74 |
| Refund to R. I. Foundation | 500.00 |
| Salaries | 15,835.20 |
| Social Security Taxes | 228.70 |
| Telephone | 233.65 |
| World War II Memorial | 233.00 |
| TOTAL | $28,860.87 |

*Exhibit C*

### SPECIAL FUNDS

*J. W. C. ELY FUND*

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1,500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

*Investments*

52 shares, New England Electric Company ($624)

*continued on page 400*

## ANNUAL REPORTS

*continued from page 398*

*Cash in General Fund of Society*

| | | |
|---|---|---|
| Balance January 1, 1948 | | $ 848.15 |
| Stock dividends, 1948 | | 52.00 |
| Total | | $ 900.15 |
| Periodicals purchased, 1948 | | —129.50 |
| Cash Balance in General Fund, January 1, 1949 | | $ 770.65 |

* * * *

*ENDOWMENT FUND*

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2/12 of the annual income, amounting that year to $69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

*Investments*

| | | |
|---|---|---|
| 16 shares, National Bank of Commerce sold for $2,159.52 Invested in Government Series G Bonds | ($2,000) | |
| Cash balance in General Fund | | $ 159.52 |
| 74 shares, Providence Gas Company | ($906.50) | |
| Dividends, 1948 | | $ 92.40 |
| Total, used for Library Building repairs | | $ 251.92 |

* * * *

*E. M. HARRIS FUND*

Established in 1921 by a donation of $5,000 by Dr. E. M. Harris for "upkeep of the Library Building."

*Investments*

| | |
|---|---|
| 25 shares, Consolidated Edison Electric Company | ($2,346.88) |
| 64 shares, Nicholson File Company | ($2,719.00) |

Dividends, 1948, (Used for upkeep of Library building)

| | |
|---|---|
| Consolidated Edison Electric Company | $ 125.00 |
| Nicholson File Company | 177.60 |
| | $ 302.60 |

* * * *

*HERBERT TERRY FUND*

Established in 1928 by a donation of $2,000 from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

*Investment*

| | |
|---|---|
| 96 shares, Providence Gas Company | ($1,152.00) |

*Cash in General Funds of Society*

| | | |
|---|---|---|
| January 1, 1948 | | $ 9.20 |
| Dividends, 1948 | | 57.60 |
| | | $ 66.80 |
| Books and periodicals purchased, 1948 | | $ 66.50 |
| Cash balance in general funds, January 1, 1949 | | $ 4.30 |

* * * *

*JAMES R. MORGAN FUND*

Established by a donation of $500 in 1929 to be used for current expenses.

*Investment*

| | |
|---|---|
| 43 shares, Providence Gas Company | ($526.75) |
| Dividends, 1948, (Used for current expenses) | $ 25.80 |

* * * *

*JAMES H. DAVENPORT FUND*

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

*Investment*

| | |
|---|---|
| 89 shares, Providence Gas Company | ($1,068.00) |

*Cash in General Fund*

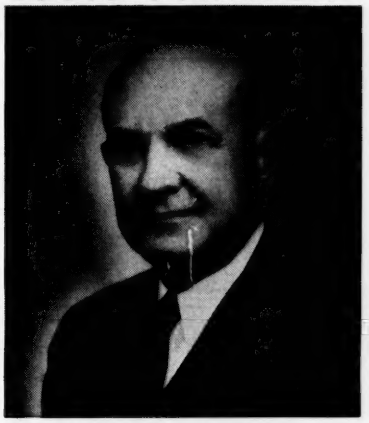
| | | |
|---|---|---|
| January 1, 1948 | | $ 983.00 |
| Dividends, 1948 | | 53.40 |
| | | $ 1,036.40 |
| Books purchased, 1948 | | 19.63 |
| Cash balance in General Fund, January 1, 1949 | | $ 1,016.77 |

* * * *

*continued on page 402*

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

# AN URGENT APPEAL TO YOUNG DOCTORS!



*Your personal help is needed to avert a serious threat to our national security!*

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

***Normal procurement channels will not provide sufficient replacements!***

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, *and who saw no active service,* to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

*We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.*

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

*Volunteer now for active duty. You are urged to contact the Office of Secretary of Defense by collect wire immediately, signifying your acceptance and date of availability. Your services are badly needed. Will you offer them?*

Louis Johnson

## ANNUAL REPORTS

*continued from page 400*

### *THE CHARLES F. GORMLY FUND*

Established by the Society in 1945 with a cash balance of $102.51 accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Society in 1943. The Fund was established for the purchase of medico-legal books to form the Charles F. Gormly collection.

| | | |
|---|---|---|
| Cash balance in General Fund, January 1, 1948 | $ | 68.22 |
| Books purchased, 1948 | | 9.90 |
| Cash balance in General Fund, January 1, 1948 | $ | 58.32 |

* * * *

### *FRANK L. DAY FUND*

Established in 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

*Investment*

3,000 shares, Canadian National Railway Company ..($2,979.75)

*Cash,* Industrial Trust Company, checking account.

| | | |
|---|---|---|
| Balance, January 1, 1948 | $ | 691.69 |
| Dividends, 1948 | | 67.50 |
| | $ | 759.19 |
| Books purchased, 1948 | | 80.74 |
| Balance, January 1, 1949 | $ | 678.45 |

CHARLES J. ASHWORTH, M.D.
*Treasurer*

### *Annual Meeting* and *Scientific Program*

Your committee is pleased to report that the arrangements for the annual meeting of the Society on May 11th and 12th have been entirely completed. A very interesting and varied program has been compiled, with presentations by a number of well-known authorities outside our Society in addition to several papers by our own members.

The Chapin Oration will be presented by Dr. Tom D. Spies of Birmingham, Alabama, the eminent expert on Nutrition and Vitamin Deficiencies.

Last winter the usual combined meeting of this Society with the Providence Medical Association was replaced by a meeting held at the Naval Air Station in Quonset. This took place on the afternoon and early evening of Wednesday, Feb. 2nd, and proved to be a most tremendous success. Socially it was very satisfactory, and there was also an interesting scientific program arranged through the Navy Department, followed by a reception and excellent dinner.

The great success of this innovation would appear to offer perhaps a solution to the problem of stimulating the interest of some of our component county societies. The complexities that have developed in connection with our regular annual meetings will probably make it very unlikely that an annual meeting could be adequately arranged outside of Providence. However, your committee believes that it would be a very desirable change to hold our so-called "mid-winter" meetings in various places in the state, changing from year to year whenever feasible. These meetings could be arranged with the aid of the local county society, and might include presentations from local members or invited guests.

We therefore recommend that the mid-winter meetings be held outside of Providence, insofar as is feasible each year.

We also recommend that these meetings be held early in December rather than February, in order to avoid the inclement weather usually prevalent during the latter month.

Isaac Gerber, M.D., *Chairman.*
S. John P. Turco, M.D.
George A. Eckert, M.D.
John F. Kenney, M.D.
Henri E. Gauthier, M.D.
Henry S. Joyce, M.D.
Herman C. Pitts, M.D.
Peter Pineo Chase, M.D.
Edgar S. Potter, M.D.

## BENEVOLENCE FUND

The Committee named by the President in accordance with the action taken by the House of Delegates at its January, 1949, meeting has met and has initiated study of the possibility of a benevolence fund for the members of the Society.

Attached to this report are statements from various State Medical Associations that have set up various types of funds such as we have under consideration. The problems associated with the project are many and varied, and include such ones as what donation would be required annually from participating members, who should be assessed, should the plan be merely a benevolence fund or should it be extended to include a retirement fund, on what basis would payments be made, etc. The committee has reached no decision on any of these matters, but it does feel that with study a sound plan could be evolved.

Therefore, the Committee asks the House of Delegates if it wishes the study continued, and if it does, that it

1. Authorize the increase of the committee from five to ten members to permit representation on it

*continued on next page*

by at least one physician from each of the district societies.

2. That the Committee be authorized to canvass the members of the Society for recommendations regarding: (a) type of plan; (b) the amount of donation per year; (c) other matters upon which the committee might desire the opinion of individual members of the Society.

David Freedman, M.D., *Chairman*
Daniel V. Troppoli, M.D.
Michael J. O'Connor, M.D.
Henry J. Hanley, M.D.
George W. Waterman, M.D.

## INDUSTRIAL HEALTH

The Committee on Industrial Health has held several meetings during the year, the work being devoted mainly to the question of revisions and amendments to the state workmen's compensation law. In the Fall of 1948 the recommendations of this Committee were approved by the House of Delegates, and after conferences with the Governor of the State and the former Study Commission on the Workmen's Compensation Law, the Committee prepared amendments in legislative form and submitted them to the Governor for possible transmission to the General Assembly. We regret to report that these amendments were not brought before the Assembly, possibly due to the fact that they would have been introduced late in the session and therefore might not receive the attention due them. The Committee hopes to see the amendments presented to the Legislature early in 1950.

Stanley Sprague, M.D., *Chairman*
James P. Derry, M.D.
Arthur E. Martin, M.D.
Herman P. Grossman, M.D.
Richard F. McCoart, M.D.
Edwin F. Lovering, M.D.
Francis E. Hanley, M.D.
Charles L. Farrell, M.D.
Joseph C. Johnston, M.D.

## MEDICAL DEFENSE AND GRIEVANCE

During the past year several cases presenting unusual features have been brought to the attention of this committee. In one instance, the physician did not carry professional liability insurance. The committee recommended settlement of the case, and the physician himself was obliged to assume the financial responsibility. Needless to say, the physician quickly purchased liability insurance. In another instance, the suit was transferred to the jurisdiction of another state. In a third case, an error in a sponge count was responsible for the legal proceeding. Settlement was recommended

*continued on page 406*

# *A Valuable Adjuvant*

## IN

# PERITONITIS

STREPTOMYCIN has proved to be a valuable adjunct in the prevention and treatment of peritonitis in the presence of streptomycin-sensitive organisms. In some instances, streptomycin in combination with penicillin and a sulfonamide has been effective in infections which had failed to respond to penicillin alone or to combined penicillin and sulfonamide therapy.

In general, the best results are obtained with optimal dosages of each of these drugs, combined with the proper surgical procedure.

It is reasonable to predict that with early diagnosis, prompt surgical intervention, and combined chemotherapy, the mortality rate from spreading peritonitis may be reduced to virtually zero, except in cases which are moribund before appropriate treatment is begun.

**STREPTOMYCIN**
**CALCIUM CHLORIDE COMPLEX**
**MERCK**

MERCK

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

## ANNUAL REPORTS

*continued from page 404*

and the hospital advised to check sponge counts more carefully in the future. The committee heard two cases in which a disagreement had arisen as to the proper charge for services rendered. In one instance, the dispute was adjusted to the satisfaction of both parties; in the second case, no final settlement has been made. The committee again wishes to emphasize the importance of reporting promptly any situation where a patient seems likely by his attitude to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment, even if the case has not been referred to a lawyer.

Roland Hammond, M.D., *Chairman*
Henri E. Gauthier, M.D.
Michael H. Scanlon, M.D.
Robert G. Murphy, M.D.
Albert H. Jackvony, M.D.
Charles J. Ashworth, M.D.
Adolph W. Eckstein, M.D.
Fenwick G. Taggart, M.D.
Robert H. Whitmarsh, M.D.
John F. Kenney, M.D.

## LIBRARY

The Library has had a busy and prosperous year, with the service to the Society and the community constantly increasing.

We have added 288 new books—24 by purchase, plus 29 from the Rhode Island Medical Journal, sent to the Journal by the publishers, for review. It may be interesting in this connection to quote from an article written by Dr. George D. Hersey, (who did more for the Library than any other Fellow). This was entitled "The Medical Library as a Factor in Medical Progress," and was published in the Providence Medical Journal, October, 1900.



"The Providence Medical Journal was conceived in the hope of thus benefiting the Medical Library, as all Journals received in exchange, and all books sent for review are placed on our shelves, and preserved for future reference."

These wise and forward-looking words were written nearly fifty years ago and the policy then outlined has been carried out consistently. We are indebted to these publishers for many new books, and are deeply appreciative.

We have also received 235 books from 13 of our Fellows, and also books and pamphlets and reprints from various organizations, to a total of 30. It will be noted that the total number of purchases has not been large, but we have bought all new works which have been deemed fitting for our Library.

In addition to these accessions, we have bound 138 volumes, mostly of the periodicals currently received. It is important to bind these, as soon as each volume is complete, as if not bound, sets are very easily broken, and it has been found by experience, in some cases, difficult to replace missing numbers even by applying to the publishers.

Circulation:—Current Journals are more in demand on loan, than are books. 1183 Journals were charged out in contrast to 292 books loaned. This is a healthy sign, as it shows the interest of the Fellows in current literature.

Reading Room:—The Reading Room is available to the Fellows, to students, and to the general public, and during the year it was visited by 2011 individuals. As a matter of interest, during the month of March, a record was kept as to the personnel of the visitors, and the following figures were found.

In the day time, 144 Fellows, 100 general public.
In the evenings, 18 Fellows, 31 general public.

For the year, the evening attendance was 95 Fellows, and 210 general public. We have used the term "general public" to indicate students, teachers, social workers, lawyers, and other non-medical readers. Students comprise the majority of the evening attendants. So that the Library is of much value in this city, where there are so many students in the various educational institutions.

An activity of the Library which has not been emphasized is the preparation of bibliographies for Fellows who are engaged in research, or the writing of papers. During the year, 170 of these were prepared by the Staff of the Library.

Miscellaneous items—

Inter-library loans
Borrowed from other Libraries, 7 Journals
4 books
Loaned to other libraries, 285 Journals
20 books

*continued on page 408*

## ANNUAL REPORTS

*continued from page 406*

289 periodicals are regularly received.

Telephone calls from Fellows and the public amount to 15 to 20 per day.

It will be of interest to state that according to the 1942 Directory of the American Medical Association, our Library was the fifth largest in the New England States, (out of 35), and the 35th in the United States, (out of 324.) Three of the four largest in New England are connected with Universities.

The fourth is of course the Boston Medical Library.

Our holdings at this date are about 38000 books, together with an unestimated number of reprints and pamphlets. Of the books, 23955 have been catalogued.

No report would be complete without some suggestion for improvement. One of the projects most necessary is a continuation of the cataloguing of the books. As has been pointed out, we have about 14000 books not yet catalogued, and these books are not available for reference. To do this work would necessitate the employment of additional clerical assistance, as the daily activities of the Library are so great that the present Staff would be quite unable to undertake such a task. It is important, however, and from the viewpoint of efficiency, much to be desired.

We are continually indebted to the Librarian, Mrs. Helen DeJong, and her co-worker, Miss Grace Dickerman, for their efficient and courteous administration of the affairs of the Library.

H. G. Partridge, M.D., *Chairman.*
Daniel D. Young, M.D.
Francis H. Chafee, M.D.
Marshall Fulton, M.D.
Ciro O. Scotti, M.D.
Israel Kapnick, M.D.
Robert T. Henry, M.D.
Whitman Merrill, M.D.

## MEDICAL ECONOMICS

The Committee on Medical Economics has continued its investigation of the question of increased fee payment for examinations done for insurance companies.

Recently the Committee met with Dr. Harold M. Frost, medical director of the New England Mutual Life Insurance Company who is the chairman of a committee of the medical directors of more than 200 life insurance companies considering this question.

So far four States, Tennessee, Oregon, New Jersey, and Rhode Island have passed resolutions regarding increased fees. Several county medical societies have also gone on record protesting the low fee paid for the insurance examination to determine the eligibility of the subscriber for the insurance coverage.

The insurance group admits that there has been no increase in fees for physicians' services in the past fifty years. The majority of the companies paid a flat $5 fee, and 14% of the companies reporting to Dr. Frost's committee indicated that they paid on a sliding basis predicated on the value of the insurance policy being purchased. This sliding fee scale has been opposed by the Rhode Island Medical Society.

The expressions of opinion by this Society are being transmitted this week to several hundred insurance company medical directors by Dr. Frost's committee. What effect, if any, this reporting will have cannot be determined. The medical directors do not set the fee, nor do they enter into the business administration of the companies. It is hoped, however, that the influence of the medical directors may be sufficient to focus attention by the companies on the discrimination towards physicians in the matter of fair fee for service as regards examinations and reports.

As previously reported to you, this problem was brought to the attention of the House of Delegates of the American Medical Association at its annual session in June, 1948, by the New Jersey State Medical Society. This resolution from New Jersey, urging that the problem be considered on a national scale since it has national effect, was referred to the Board of Trustees of the AMA who in turn have requested that the Bureau of Economic Research study the matter and report back. Such a study report is being made to the AMA Trustees within the month, and therefore the findings will be brought to the attention of the House of Delegates at the meeting in Atlantic City this June.

In view of these circumstances, your Committee recommends that the Rhode Island Medical Society re-affirm its stand on the matter of fees paid for insurance examinations, and that it instruct its delegate to the House of Delegates of the American Medical Association to make known the views of this Society in any discussion that may arise relative to this matter.

William P. Davis, M.D., *Chairman.*
William B. Cohen, M.D.
H. Frederick Stephens, M.D.
Samuel D. Clark, M.D.
William A. McDonnell, M.D.
Louis A. Morrone, M.D.
Edmond C. Laurelli, M.D.
Alfred M. Tartaglino, M.D.
Hubert Holdsworth, M.D.

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## ANNUAL REPORTS

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### POSTGRADUATE EDUCATION

The Postgraduate Education Committee has not been active during the year other than to promote through the Rhode Island Medical Journal and the Rhode Island Medical Library announcements of clinics, conferences, and ward rounds held at various hospitals that are of educational value. There are no specific recommendations of the Committee to be made to the House of Delegates.

Marshall N. Fulton, M.D., *Chairman.*
Alex M. Burgess, M.D.
Frank B. Cutts, M.D.
Isadore Gershman, M.D.
Laurence A. Senseman, M.D.
David G. Wright, M.D.
Hannibal Hamlin, M.D.
B. Earl Clarke, M.D.
James C. Callahan, M.D.

### PUBLIC POLICY AND RELATIONS

The Committee has had several meetings throughout the year. Its first task was to receive a Resolution from the Woonsocket Medical Society regarding medical licensure. The Committee met with representatives of the Society and the State Board of Examiners in Medicine. After a thorough discussion it returned a report to the House of Delegates which was read at the previous meeting.

Following this the PROVIDENCE EVENING BULLETIN ran an article on American Medicine and the Committee published a series of articles in rebuttal. This series entitled, "Rhode Island Medicine — Its Problems and Solutions" has been printed and is available in the library and in the schools.

The Committee has been cognizant of the attitude of the Press and has worked diligently to improve public relations on this basis. Your Chairman has interviewed the Editorial Board of the PROVIDENCE JOURNAL BULLETIN and the PAWTUCKET TIMES. We have offered to cooperate with the newspapers in supplying them with facts and material for background in their study of any health problem affecting this State.

The Committee has been active in promoting public relations in the various District Medical Societies and your Chairman attended the interim session of the American Medical Association in St. Louis where he was indoctrinated with the attitude of the A. M. A. toward public policy and relations. This meeting was extremely helpful and new techniques were studied in relation to District Society activities.

The Committee has been active in replying to adverse newspaper articles and correcting erroneous impressions disseminated by supporters of compulsory government medicine. The Committee has kept a complete file of newspaper articles and news stories. Your Chairman has participated in the activities of the Council of the New England Medical Societies and, in company of the other members of the Committee, has spoken before various groups and on the radio on the subject of Health Insurance.

Your Committee has also thoroughly investigated and checked the reports in the Press that bookies and other petty criminals were released by police on the certificate of a physician. Full reports on these cases have been submitted to the Council and, to date, every instance of such release appears to be for genuine illness and certificates were provided only to persons who were really suffering from clinical disorders.

The Committee has had some lantern slides prepared and several speeches mimeographed for use in public discussions on socialized medicine. It is expected that the Committee will enlarge this field of activity in the coming months.

The Committee has also heard evidence from several sources regarding minor problems not important enough to detail in this report.

Charles L. Farrell, M.D., *Chairman*
Peter F. Harrington, M.D.
Earl J. Mara, M.D.
Clifton B. Leech, M.D.
Morris Botwin, M.D.
Harry Hecker, M.D.
Joseph W. Reilly, M.D.
Charles J. Ashworth, M.D.
Peter Pineo Chase, M.D.

# DISTRICT SOCIETY MEETINGS

## PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held May 19, 1949, in the Nurses' Dining Room of Memorial Hospital. This was a dinner meeting. Nineteen members attended. The minutes of the previous meeting were read by the Secretary and accepted.

The application for membership in the Society from Dr. William Norman Pineault was read and referred to the Standing Committee. The following two applications were read as approved by the Standing Committee, to be voted upon at the next regular meeting; Dr. John Crane O'Neil, Dr. Eugene Edward Gaudet.

Dr. Albert Gaudet reported on the Doctors' Emergency Call Panel and stated that the plan was working well.

Dr. Fox and Dr. Mara reported on recent developments in the Voluntary Prepaid Surgical Plan.

It was unanimously approved that the Secretary write to Governor John O. Pastore commending him for his action in vetoing the recent so-called Doctors' Bill.

The scientific session followed in the Nurses' Auditorium where Dr. Gertrude Muller spoke on "Child Guidance in Action." A case of true Hermaphroditism was presented and the conduct of the case was discussed by Dr. Muller together with the Chief Psychiatric Social Worker of the Clinic, Mrs. Elizabeth McCormick and the Chief Psychologist Mr. Kennerson T. Bosquet. Dr. Laurence Senseman presided as chairman.

The meeting adjourned at 10:00 p.m.

Respectfully submitted,

K. W. HENNESSEY, M.D., *Secretary*

## NEWPORT COUNTY MEDICAL SOCIETY

On May 28, 1949, the Newport County Medical Society held a joint meeting with the Newport County Dental Society. Sixteen members from each society attended.

Dr. Philomen Ciarla, President, opened the meeting at 9:00 p.m. and welcomed the allied Society.

Communications were read. The Educational Campaign of the A.M.A. as presented by Whitaker and Baxter was discussed.

There was no old business.

Dr. Donald Fletcher's motion that the Newport County Medical Society appoint a committee on the Cancer Detection Clinic consisting of the President of the Newport County Medical Society, Dr. Callahan, Dr. Mayner and Dr. Fletcher, was seconded by Dr. Henry Brownell and approved.

Our summer meeting was omitted and Dr. Grimes and Dr. Bestoso sponsored a motion to have a clambake at Dr. Adelson's summer home. An amendment by Dr. Adelson to have a clambake committee of three was approved.

Dr. Francis McCarthy of Tufts Medical School, our guest speaker, spoke on "Oral Medicine" and showed 100 slides.

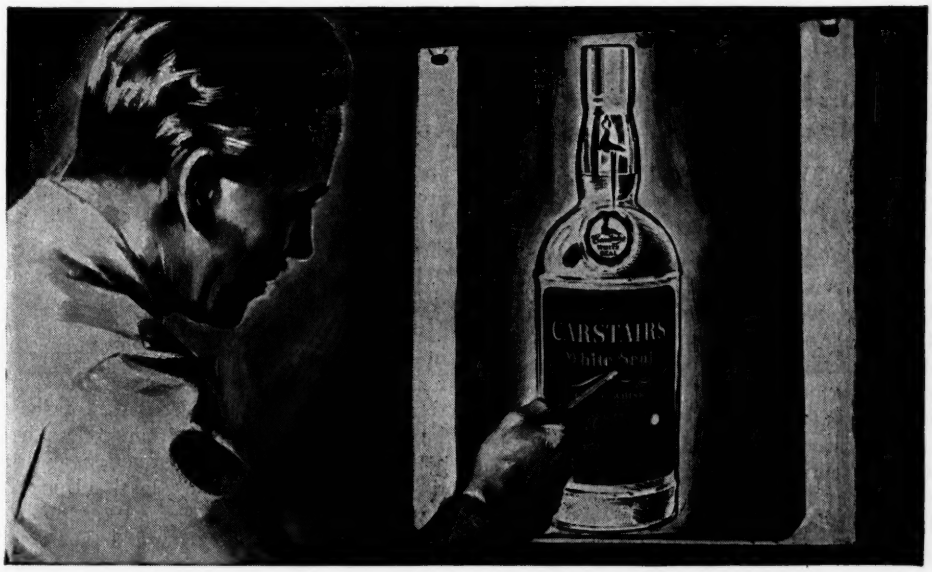
The meeting adjourned at 11:00 p.m. Collation followed.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

***Dr. Joseph C. O'Connell, retiring President of the R. I. Medical Society, turns over the gavel to incoming President, Dr. Peter Pineo Chase.***

# EVER X-RAY A WHISKEY?

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# BOOK REVIEWS

*HOW TO BECOME A DOCTOR* by George R. Moon. The Blakiston Company, Philadelphia, 1949.

Mr. Moon, Examiner and Recorder at the University of Illinois Colleges of Medicine, Dentistry and Pharmacy, is well qualified to answer the many questions of the young men and women who desire to enter the medical profession. His book contains practical information about choosing a medical school, financing a medical education and the problems of the medical student. He devotes three chapters to dentistry, pharmacy and professional fields closely allied to medicine.

This book will prove most helpful to the many students who use our Library.

HELEN DEJONG, *Librarian*

*THE FOOT AND ANKLE: THEIR INJURIES, DISEASES, DEFORMITIES AND DISABILITIES,* by Philip Lewin, Third Edition, 1947, Lea & Febiger. 821 pages, including fairly extensive bibliography.

At the recent annual meeting of the Academy of Orthopedic Surgeons, two instructional courses on "practical foot problems" were included in the program and were well attended. It was justly stated that the medical profession as a whole has failed to give disabling foot conditions the study and attention they deserve. Lewin's book is primarily directed to the general practitioner, attempting to tell him what to do for the common foot conditions and ailments. The writer's style is somewhat didactic, reflecting his teaching experience at a medical school, and this is sometimes of advantage in a voluminous work devoted to the foot and ankle.

The author emphasizes that the value of footprints has been overestimated from the standpoint of both diagnosis and progress of foot ailments. Rolling-in (pronation) of the foot is the most significant and common mechanical factor in producing foot strain and disability. Lewin states that "there is no exclusive type of arch that can be considered the normal. The height and shape of the longitudinal arch do not determine the strength or usefulness of the foot."

In discussing the surgical treatment of hallux rigidus, the author failed to include the Keller operation (proximal hemi-phalangectomy of the great toe) which is considered by many orthopedic surgeons to be the procedure of choice in this condition.

In the treatment of wounds of the foot and ankle seen early and debrided thoroughly, the author approves the application of sulfanilamide powder in the depths of the wound prior to primary closure. Extensive investigation during World War II on this subject, however, had led to the conclusion that local sulfanilamide powder produced local irritation and excessive granulation formation, and present-day opinion advises against local sulfonamides in wounds.

A few significant typographical errors were noted, one describing the injection of the posterior tibial nerve behind the *external* (instead of internal) malleolus (page 583), and another discussing the removal of the first metatarsal (the word "head" being omitted) for hallux valgus (page 227).

The book in general comprises an excellent comprehensive study of the disorders and treatment of the foot and ankle, proceeding systematically from the embrology and anatomy, physiology and biomechanics of these structures, through detailed examination of the foot and ankle; then the various categories (congenital deformities, static defects, affections of the individual toes, heel, epiphyseal disturbances, fractures, infections, vascular and neurological disturbances, etc.) are dealt with in painstaking fashion. The text is definitely readable, and the author concludes with a series of aphorisms, or "pedigrams," one of which is directed to all of us:—

"Physician! know thy feet."

CAROLL M. SILVER, M.D.

*THE BUSINESS SIDE OF MEDICAL PRACTICE* by Theodore Wiprud. Philadelphia, W. B. Saunders Co. Second Edition, illustrated. 1949.

This book, dealing with the business aspects and medical economics in the practice of medicine, is a second edition and has been completely rewritten in many parts. New bibliographies have been substituted and three new chapters have been added. These are, "Opportunities for Medical Leadership"—"Group Medical Practice" and "The Doctor Looks to the Future."

The author has been intimately associated with physicians in city and in rural practice for approximately sixteen years. He has been business manager for a group of physicians and later an executive secretary of one of the larger County Medical Societies and is well qualified to write on this subject.

This book was first written in an attempt to show doctors the basic fundamentals of the business side of medicine in which we must all deal whether we like to do so or not. He also points out the fact that this aspect of medical practice has been entirely neglected, not only in our medical school education, but also in premedical school education for the most part. He feels that future doctors should take some business training either in college or medical school and preferably the medical school should add such courses to their curriculi. On the whole the book is extremely well written. In some places it does not seem to go into quite as much detail as one might wish but most of the chapters are entirely adequate. He enters into many various fields such as public speaking, relationship with the press, how to adequately conduct a meeting, how to handle accounts etc. I think that this book is good reading for any doctor whether he is just starting in practice or has been in practice for many years. It is of excellent value at the present time because of the point it brings out in proper public relations for the medical profession.

*Summary*: I found this book by the author on "The Business Side of Medical Practice" very excellent reading and obtained many helpful points in so doing. I think that because of the present status of medicine in relation to the public, especially in this State, all doctors would profit by reading this book in how to properly approach such public relation problems. The various chapters in the business side of the practice such as "Accounts"—"How to Bill Patients" — "How to Collect Overdue Accounts"—"Necessary Financial Records"—"How to Manage an Office" and "How to Go About Building a Medical Practice" are all of great value. I strongly recommend this book to all doctors.

ROBERT C. HAYES, M.D.

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